



LAKESHORE CAP, INC.

Supportive Housing Program Application

MANITOWOC County	SHEBOYGAN County	DOOR/KEWAUNEE Co
<p>BRING your application to our office at: 702 State Street- 2nd floor (corner of State and 7th streets)</p> <p>MAIL to PO Box 2315, Manitowoc, WI 54221-2315</p> <p>FAX to 920.686.8700</p> <p>EMAIL to info@lakeshorecap.org</p> <p>CALL 920.682.3737</p>	<p>BRING/MAIL your application to our office inside the <u>Sheboygan County Job Center</u> at 3620 Wilgus Avenue, PO Box 896, Sheboygan, WI 53082-0896</p> <p>FAX to 920.694.0291</p> <p>EMAIL to info@lakeshorecap.org</p> <p>CALL 920.803.6691</p>	<p>BRING to 131 S. 3rd Ave., Sturgeon Bay (limited open office hours)</p> <p>MAIL to PO Box 791, Sturgeon Bay, WI 54235-0791</p> <p>FAX to 920.746.0142</p> <p>EMAIL to info@lakeshorecap.org</p> <p>CALL 920.743.0192</p> <p><i>*May also send to Manitowoc office</i></p>

- Your application will be reviewed by a Case Manager in the order in which it was received. Because we receive many applications, it may be a week or two before you will be notified of your eligibility.
- You will be notified IN WRITING (by mail, if possible) of the outcome of your decision within 14 days.
- Be sure to fill out **EVERY** answer in the application packet. Failure to do so will result in a delay of the decision.
- Once your application is reviewed, it will either be **Pending** or **Not Eligible**.
 - If you are Not Eligible, your case will be closed.
 - If your circumstances change, you will need to re-apply.
 - If you are Pending, you will receive a request to provide us some additional information, including:
 - Income from the previous 30 days prior to your application;
 - Proof of any benefits that you receive, such as Food Share or Badgercare;
 - Documentation of your checking or savings account balances from the last 30 days;
 - Eviction notice;
 - Valid, written lease;
 - Copy of ID's for all adults and Social Security cards for all household members.
 - You will have 14 days to provide the requested information or your application will automatically close. You can speed up the determination process if you provide the information with this application!

1. *Our application is lengthy and requires a lot of information up front. This is due to the funding that we receive. Each question is important and helps us determine your eligibility. We also need the information to report back to our funders the demographics about those requesting our assistance.*
2. *If you are eligible, it will take several weeks to go through our entire process.*
3. *You may also Appeal the decision or file a Grievance if you feel that you were treated unfairly. The information to do so is attached to this application and you should keep it.*
4. *Feel free to call our office with any questions.*

Thank you for taking the time to apply for our assistance. We will make every effort to direct you to resources that may be helpful to you and your family.

WI BALANCE OF STATE CoC Pre-Screen Form



Are you a domestic violence victim or survivor? Yes No

If yes, would you like a referral to a local DV agency? Yes No

If yes, when last experience occurred? _____

If yes, are you currently fleeing a domestic violence situation? Yes No

Do you have a disability or need reasonable accommodations for us to provide services to you, including filling out this form? (this question is voluntary and does not affect your eligibility for services) Yes No

List Accommodations needed:

Do you need an interpreter? Yes No Language? _____

Household members (List everyone living in your household, related & unrelated)

Head of Household								/	/
Last	First	Middle	Gender	<input type="checkbox"/> Disabled	Race	Ethnicity	Date of birth		
_____	_____	_____	_____	<input type="checkbox"/>	_____	_____	____/____/____		
_____	_____	_____	_____	<input type="checkbox"/>	_____	_____	____/____/____		
_____	_____	_____	_____	<input type="checkbox"/>	_____	_____	____/____/____		
_____	_____	_____	_____	<input type="checkbox"/>	_____	_____	____/____/____		
_____	_____	_____	_____	<input type="checkbox"/>	_____	_____	____/____/____		

Current Address: _____
Street
Apt. #
City
State
Zip Code

Telephone No: _____ Email: _____

Living situation last night

- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Place not meant for habitation inclusive of "non-housing service site (outreach programs only)"
- Safe haven

When did this homelessness experience start (not necessarily when you entered shelter)? / /

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Rental by client, no housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with other housing subsidy (including RRH) <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center | <ul style="list-style-type: none"> <input type="checkbox"/> Other _____ <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Long term care facility or nursing home <input type="checkbox"/> Rental by client with GPD or TIP subsidy <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital (non-psychiatric) <input type="checkbox"/> Owned by client, no housing subsidy <input type="checkbox"/> Owned by client, with housing subsidy |
|--|--|

WI BALANCE OF STATE CoC Pre-Screen Form



Length of living situation in place marked above.

- One night or less
- 2-6 nights
- One week but less than a month
- One to three months
- More than three months, but less than one year
- One year or longer

Estimate how much longer you expect to reside there.

- Can't go back
- More than a year
- Until shelter/housing is received
- Less than 3 months
- 3 months to a year

Number of times you have been on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years including today: _____ times

Number of months homeless on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years: _____ (not exceeding 36 months)

Veteran Status Never in the Service Currently in the Service Veteran
Veteran Benefit Status Currently receiving Currently not receiving Never received

Cause of homelessness (check all that apply).

- Divorce/Separation
- Domestic Violence
- Eviction
- Thrown out
- Loss of job
- Low income
- Mental illness
- Substance abuse
- Parole/incarceration
- Ran Away
- Exiting** Foster care
- Rent increase
- Other _____

FUP Eligible Family _____ **FUP Eligible Youth** _____
**For public child welfare agencies only, FUP eligibility must be determined by the PCWA in your county*

INCOME: (Please list all sources of income)

Source: _____ Gross monthly amount \$ _____
 Source: _____ Gross monthly amount \$ _____
 Source: _____ Gross monthly amount \$ _____

NO INCOME – Do you certify that you do not have any income from any source at this time?
 Yes No **VERBAL**

Do you give consent that this agency may share information with other agencies such as, but not limited to, your situation, household demographics, and any questions asked during this assessment for the purpose of providing a referral to Coordinated Entry Prioritization Lists?
 Yes No **VERBAL**

I understand that the information contained on this form is provided voluntarily. The information is true and correct to the best of my knowledge. I am aware that providing false information or not reporting pertinent information is fraud. If I provide any false information, I understand that services may be denied. I understand that completion of this form does not guarantee that I will receive assistance.
 VERBAL

Signature of Applicant _____ Date: _____
 Signature of CoC Agency Rep _____ Date: _____

Household Members *List yourself and everyone living in your household, related & unrelated.*

Circle "IN SCHOOL" (Y or N) for everyone. Check "NOT WORKING" for every household member it applies to, INCLUDING children.

#1 YOU				SS #				Marital Status:	
In School?	Y / N	Highest grade completed?		Graduate?	Y / N / GED	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender			
Employed?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal			Unemployed?	<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <input type="checkbox"/> Retired				
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:								

#2 Name				SS #				Marital Status:	
In School?	Y / N	Highest grade completed?		Graduate?	Y / N / GED	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender			
Employed	<input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Migrant Seasonal Farm			Unemployed	<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <input type="checkbox"/> Retired				
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:								

#3 Name				SS #				Marital Status:	
In School?	Y / N	Highest grade completed?		Graduate?	Y / N / GED	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender			
Employed?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal			Unemployed?	<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <input type="checkbox"/> Retired				
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:								

#4 Name				SS #				Marital Status:	
In School?	Y / N	Highest grade completed?		Graduate?	Y / N / GED	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender			
Employed?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal			Unemployed?	<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <input type="checkbox"/> Retired				
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:								

#5 Name				SS #				Marital Status:	
In School?	Y / N	Highest grade completed?		Graduate?	Y / N / GED	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender			
Employed?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal			Unemployed?	<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <input type="checkbox"/> Retired				
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:								

#6 Name				SS #				Marital Status:	
In School?	Y / N	Highest grade completed?		Graduate?	Y / N / GED	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender			
Employed?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal			Unemployed?	<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <input type="checkbox"/> Retired				
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:								

Request additional page if needed

Non-Cash Benefits

<input type="checkbox"/> SNAP (FoodShare) \$ _____/Mo	<input type="checkbox"/> WIC (Women & Children)	<input type="checkbox"/> LIHEAP/WHEAP (Energy Asst)	<input type="checkbox"/> Childcare Voucher
<input type="checkbox"/> Housing Choice Voucher (Section 8)	<input type="checkbox"/> Public Housing (Low Income)	<input type="checkbox"/> HUD-VASH (Veterans)	<input type="checkbox"/> Other
<input type="checkbox"/> Permanent Supportive Housing (Mental Health Housing Program)		<input type="checkbox"/> Affordable Care Act Subsidy	

Disability — Long Term Short Term

If you indicated Disabled on Page 1, please check:	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Mental Health <input type="checkbox"/> HIV/AIDS		
<input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Both Drug & Alcohol Abuse <input type="checkbox"/> Other:			
First name of person(s):			Approximate year it started:
Do they currently receive SSI or SSDI?	Y / N	Are they currently receiving other medical services?	Y / N

NECESSARY INFORMATION!

Current or Future Rental Housing

1. What kind of help are you requesting?			
2. How much are you behind in rent?	\$	Do you plan to:	<input type="checkbox"/> Stay <input type="checkbox"/> Move
3. Do you have a written EVICTION NOTICE ?	YES / NO	Circle type:	5-day 14-day 28-day Court Summons
4. Explain why you are or were unable to pay your rent or security deposit:			
5. How will you pay future rent?			
6. What other agencies have you contacted for help?			
7. What was the outcome?			

Unit Details

Landlord Name		Landlord Phone #	
Are you related to your landlord?	YES / NO	If YES, how?	
Type of Unit:	<input type="checkbox"/> Apartment Building <input type="checkbox"/> Duplex or Townhouse <input type="checkbox"/> Single Family <input type="checkbox"/> Mobile Home		
How many persons in household?		# of bedrooms?	Monthly rent? \$

Utilities & Appliances

Check One:

	Provided by Owner	Provided by Tenant
Heating (Circle one) Natural Gas Electric Bottle Gas Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cooking (Circle one) Natural Gas Electric Bottle Gas Other:	<input type="checkbox"/>	<input type="checkbox"/>
Electricity	<input type="checkbox"/>	<input type="checkbox"/>
Air Conditioning	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>
Water Heating (Circle one) Natural Gas Electric Bottle Gas Other:	<input type="checkbox"/>	<input type="checkbox"/>
Sewer	<input type="checkbox"/>	<input type="checkbox"/>
Trash Collection	<input type="checkbox"/>	<input type="checkbox"/>
Range/Microwave	<input type="checkbox"/>	<input type="checkbox"/>
Refrigerator	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

.....

IF APPLICABLE

Domestic Abuse			
➤ If you indicated "YES" for domestic violence or abuse on Page 1 , when did the abuse occur? Check one:			
<input type="checkbox"/>	Within the past 3 months	<input type="checkbox"/>	6-12 months ago
<input type="checkbox"/>	3-6 months ago	<input type="checkbox"/>	More than 12 months ago

Child Welfare/Foster Care	
➤ Are you or anyone in your household formerly the ward of child welfare or a foster care agency?	
If YES	Name(s):
	Age(s) of child(ren) when they left the foster care system:

Lakeshore Community Action Program, Inc.
AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

I/we give Lakeshore CAP, Inc. permission to contact landlords, social service agencies and other sources to obtain information necessary regarding my household's housing situation, income/budget, program eligibility and status of my case. I/we authorize the exchange of information between agencies to determine eligibility and/or on-going case management to determine program assistance.

Entity authorized to use, disclose, or receive information: Lakeshore CAP 702 State Street, PO Box 2315 Manitowoc, WI 54221-2315 Phone: 920-682-3737 Fax: 920-686-8700	 LAKESHORE CAP, INC.
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This authorization permits the use or disclosure of information: ➤ For the length of duration of services with Lakeshore CAP, or 12 months from the below signed date, whichever comes first.
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NOTICE OF RIGHTS WITH RESPECT TO RELEASE OF INFORMATION AUTHORIZATION

- **Right to refuse to sign this authorization:** You are not required to sign a release of information and you may refuse to do so. Signing this form is not a condition of participation in Lakeshore CAP supportive housing programming.
- **Right to receive a copy of this authorization:** You have the right to receive a copy of your release of information if you choose to sign it and request a copy verbally.
- **Right to revoke this authorization:** You have the right to revoke your release of information at any time. Revocation of this release of information must be made in writing to Lakeshore CAP. The written revocation will be effective upon receipt *except* for any use or disclosure of information that took place prior to its receipt.

I understand the contents of this form. I agree that a photocopy or facsimile copy of this authorization is as valid as the original. I understand that I may request a copy of this form.

I am the person/household whose information is authorized to be used or disclosed. This form accurately reflects my wishes and I authorize the use or disclosure of information as described in this form.

➤ **To be signed by everyone in your household over 18. (Use reverse side if necessary.)**

Print Name _____
 Signature _____

Date of Birth _____
 Date _____

Print Name _____
 Signature _____

Date of Birth _____
 Date _____

LCAP Staff Signature _____

Date _____



LAKESHORE CAP, INC

Acknowledgement of Appeal Process, Grievance Procedure & Non-Discrimination Policies

SIGN HERE . . .

By signing this form, I acknowledge that I have received a copy of the:

- Lakeshore CAP Appeal Process
- Lakeshore CAP Grievance Procedure & Non-Discrimination Policy

Head of Household Signature

Date

OR SIGN HERE IF . . .

You are **NOT** accepting the Appeal Process or Grievance Policy & Non-Discrimination pages.

I acknowledge that I have been offered a copy of the Lakeshore CAP policies and procedures listed above but have declined to take a copy today. I understand that if I request a copy in the future, I will be provided one.

Head of Household Signature

Date

Lakeshore CAP Staff Signature

Date



LAKESHORE CAP, INC.

GRIEVANCE PROCEDURE & NON-DISCRIMINATION POLICY

Lakeshore CAP, Inc. has an appeal/grievance procedure. Be advised that if the level of service provided is not satisfactory, all clients have the right to file a grievance and appeal the decision with the Lakeshore CAP office listed below:

Lakeshore CAP, Inc. 702 State Street, PO Box 2315, Manitowoc, WI 54221-2315 – Phone: 920-682-3737 or 1-800-924-0510

Any applicants or participants have the right to appeal decisions when they feel they have been treated unfairly with regard to agency services. It is preferable that complaints be filed as soon as possible after the incident. The prompt filing of a complaint will result in a more accurate and effective investigation. Applicants or participants should provide a written complaint to the program supervisor, who will review the complaint. If a participant cannot complete a written statement, reasonable accommodations can be made or they may provide an oral statement to the department supervisor.

The person to whom the complaint/grievance is submitted will have ten (10) working days to act on the complaint. It is this person's responsibility to meet with all parties concerned, gather necessary information and attempt to work out a satisfactory solution. This person will document their efforts to resolve the grievance in writing and submit it to Lakeshore CAP's EEO/Affirmative Action Officer.

The EEO/Affirmative Action Officer then has ten (10) working days to act on the complaint/grievance. If the EEO/Affirmative Action Officer does not arrive at a solution the complaint/grievance will be submitted to the agency's Chief Executive Officer (CEO).

The CEO has twenty (20) working days from receipt of the complaint/grievance to act on it. If a grievance remains unresolved past the level of the CEO the grievance will be submitted to the Chairperson of the Board of Directors, who will take the matter to the Executive Committee for consideration.

The Executive Committee will have twenty (20) working days from its receipt to resolve the grievance. Applicants or participants may be asked to be present. All decisions made by the Executive Committee are final.

Non-Discrimination Policy

It is the policy of Lakeshore CAP, Inc. not to discriminate against any applicant/participant requesting services because of age, race, religion, color, handicap, gender, physical condition, developmental disability, marital status, political affiliation, criminal convictions, sexual orientation, family status, lawful source of income, status as a victim of domestic abuse, sexual abuse or stalking, or national origin. Eligibility for services will be determined by stipulations of funding sources and program policies/procedures.



LAKESHORE CAP, INC.

APPEAL PROCESS

Lakeshore CAP, Inc. has an appeal procedure. Be advised that if the level of service provided is not satisfactory, all clients have the right to file an appeal of the decision with the Lakeshore CAP office listed below:

Lakeshore CAP, Inc., 702 State Street, PO Box 2315, Manitowoc, WI 54221-2315

Any applicants or participants have the right to appeal decisions that were determined if they believe the outcome was determined in error. The prompt filing of an appeal will result in a more accurate and effective investigation. Listed below is the process in which to file an appeal:

- **Step One: Written Statement:** Applicant must submit a written statement outlining the specific reasons why they believe the determination in their case was made in error. If a person is unable to complete a written statement, reasonable accommodations can be made or they can provide an oral statement to the department supervisor.
- **Step Two: Supervisor Review:** Written appeal statement will be presented to the department supervisor and supervisor will be allowed 5 business days to gather information and respond in writing to applicant.
- **Step Three: Resubmission of Statement:** Applicant will have an additional 5 business days to submit arguments. Upon submission, statement will be presented to the Lakeshore CAP CEO to review. CEO will submit a written response within 5 business days of receipt to the applicant.
- **Step Four: Final Review:** If applicant is dissatisfied with this ruling and previous steps have been addressed, a review meeting may be scheduled to discuss and provide a final ruling on the appeal. Lakeshore CAP Board may be in attendance.

CLIENT COPY — PLEASE KEEP